DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	HAND HUMAN SERVICES & MEDICAID SERVICES	DTC	3/8/10	FOR	D: 01/28/2010 M APPROVEI D. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE	SURVEY LETED
NAME OF PROVIDED OF SUPPLIES	445071	B. WING	9	01/	C 22/2010
NAME OF PROVIDER OR SUPPLIER CLAIBORNE COUNTY NURSII	NG HOME	S	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	COMPLETION DATE
SS=D	REATMENT OF RESIDENTS velop and implement written	F 22	6		
mistreatment, negle	ct, and abuse of residents n of resident property.		F226 Resident # 1 cited in the defi	cient	
This REQUIREMEN by: Intakes: TN0002459	T is not met as evidenced 7		practice was assessed by the staff on 11 p.m. to 7 a.m. shi time of observation of injury event was reported to the fol	ft at the . This	
and interview, the fac	cord review, policy review, cility failed to implement g and report unknow injury.		shift (7 a.m. to 3 p.m.) informurse receiving report that the Resident had a 3 cm X 1 cm	ming the	
The findings included	i:		on left side of forehead. The to 7 a.m. nurse assessed the	11 p.m.	
Resident #1 was adm February 9, 2000, wit Dementia, Diabetes, Hypertension.	h diagnoses including		Resident but failed to comple occurrence report, notify phy and family, as well as chart t finding in the Resident recor	vsician he d as per	
dated November 11, 2 had short and long ter moderately impaired of extensive assist for tra ambulatory, had physi	of the Minimum Data Set 2009, revealed the resident memory problems, had decision making skills, was ansfers, and was non cally abusive behaviors and		facility policy. After the Dire Nursing became aware of the occurrence, the physician wa notified and an order for radiological study was receiv completed. Results of the stu	es ved and	
B. The charge nurse is	policy Abuse revealedII.		were negative. A thorough investigation of the occurren immediately initiated. An att was made by the Director of	empt	
affected resident to as	sess: 1. Physical status: a. Investigation, reporting and ty will conduct and		Nursing to notify Resident's kin by telephone but a messa to be left requesting the neph call the facility. The nephew	ge had new to	
January 21, 2010, at 1	N (Director of Nursing) on 0:10 a.m., in the DON's		notified of the occurrence on 12/01/09 by the Director of N Electronic self report to the S	Nursing.	
ATORY DIRECTOR'S OR PROVIDERS	SUPPLIER REPRESENTATIVE'S SIGNA	TURE	Administrator	5 /	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NTEZ11

Facility ID: TN1301

If continuation sheet Page 1 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/28/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 445071 01/22/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1850 OLD KNOXVILLE ROAD CLAIBORNE COUNTY NURSING HOME TAZEWELL, TN 37879 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 226 483.13(c) STAFF TREATMENT OF RESIDENTS F 226 SS=D describing failure to follow policy The facility must develop and implement written and procedure was completed on policies and procedures that prohibit 12/01/09. On 12/04/09 a Psychiatric mistreatment, neglect, and abuse of residents and misappropriation of resident property. consult was completed with orders to increase Depakote to 250mg twice a day due to increased This REQUIREMENT is not met as evidenced combative behavior. This order was by: received and carried out on Intakes: TN00024597 12/04/09. Responsible person: Director of Based on medical record review, policy review, Nursing. Completion Date and interview, the facility failed to implement 12/04/2009 2/4/2009 policy for investigating and report unknow injury. The MDS Coordinator will review The findings included: 100% of Resident charts to ensure Resident #1 was admitted to the facility on that the C.N.A. worksheets and care February 9, 2000, with diagnoses including plans are current and complete. Dementia, Diabetes, Psychosis, and 100% of Resident rooms have been Hypertension. audited by Ward Clerks to ensure that all patient care/safety items are Medical record review of the Minimum Data Set in appropriate use as listed on the dated November 11, 2009, revealed the resident worksheets and care plans. had short and long term memory problems, had Responsible person: Director of moderately impaired decision making skills, was extensive assist for transfers, and was non Nursing. Completion Date ambulatory, had physically abusive behaviors and 02/05/2010 2/05/2010 was resist to care. The L.P.N. involved in the cited Review of the facility's policy Abuse revealed ... II. deficient practice was counseled by

B. The charge nurse is to go directly to the affected resident to assess: 1. Physical status: a. Bruises and welts ...2. Investigation, reporting and response. 1. The facility will conduct and investigation of an alleged abuse/neglect ...

Interview with the DON (Director of Nursing) on January 21, 2010, at 10:10 a.m., in the DON's

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

the Director of Nursing about the

importance and proper method of

report. L.P.N. was also counseled

completing a timely occurrence

regarding timely notification of physician and family member

(X6) DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2010 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		445071			C		
	PROVIDER OR SUPPLIER	L		REET ADDRESS, CITY, STATE, ZIP CODI 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879		22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE	
F 226 SS=D	()		F 226	followed by documentation action in the appropriate pla Responsible person: Director Nursing. Completion Date 12/01/09.	nces. or of	12/1/20	
	by: Intakes: TN0002458 Based on medical re and interview, the fa policy for investigati The findings include Resident #1 was ad February 9, 2000, w Dementia, Diabetes, Hypertension. Medical record revie dated November 11, had short and long te moderately impaired extensive assist for te ambulatory, had physical resident to a Bruises and welts	ecord review, policy review, scility failed to implement and and report unknow injury. d: mitted to the facility on ith diagnoses including, Psychosis, and w of the Minimum Data Set 2009, revealed the resident erm memory problems, had decision making skills, was ransfers, and was non sically abusive behaviors and is policy Abuse revealedII. is to go directly to the assess: 1. Physical status: a. 2. Investigation, reporting and		Staff education for 100% of care staff regarding the Abu Policy and Procedure, stress need for immediate complete occurrence report and notify physician and family members test administered with an established. Any employee receiving less than 90% had immediate remediation to a passing score. Responsible person: Educate Coordinator. Completion Educate Coordinator. Completion Educate Coordinator. The Director of or Asst Director of Nursing ensure timely completion of occurrence report and notify physician and family members well as documentation in the Resident's record. This revenue completed on a daily basis of Monday through Friday. Or weekends and holidays the 3 p.m. R.N. Charge Nurse version of the policy of the process of the	sing the sing the sing the sing the sing the sing the sing of section of section of section section section section of section section section section section of section of section of section se	12/17/09	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	120020000000000000000000000000000000000	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDIN	IG	COMP	C	
	445071	B. WING _		01/	22/2010	
AME OF PROVIDER OR SUPPLIEF	SING HOME	1	REET ADDRESS, CITY, STATE, ZIP CO 850 OLD KNOXVILLE ROAD AZEWELL, TN 37879			
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
The facility must depolicies and process and process and process and mistreatment, neggand misappropriate. This REQUIREMED by: Intakes: TN000248 Based on medical and interview, the feature policy for investigate. The findings included Resident #1 was as February 9, 2000, we Dementia, Diabetes Hypertension. Medical record revisated November 11 had short and long moderately impaired extensive assist for ambulatory, had phywas resist to care. Review of the facility B. The charge nurse affected resident to Bruises and welts response. 1. The facility response response. 1. The facility response respo	lect, and abuse of residents ion of resident property. INT is not met as evidenced and a second review, policy review, facility failed to implement ting and report unknow injury. In the second review, policy review, facility failed to implement ting and report unknow injury. In the second review, policy review, facility failed to implement ting and report unknow injury. In the second review, policy review, facility on with diagnoses including second report unknow injury. In the second review, policy on with diagnoses including second report unknow injury. In the second review, policy on with diagnoses including second report unknow injury. In the second review, policy review, facility on with diagnoses including second report unknow injury. In the second review, policy review, facility on will conduct and second report unknow injury. In the second review, policy review, facility on will conduct and second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second report unknow injury. In the second review, policy review, facility on will a second	F 226	review previous shifts worksheets/report sheets to any reported unusual occur completion of occurrence retimely notification of physical family member and chart documentation. Results of will be aggregated and reported the Nursing Home Administ Medical Director, Quality Management Committee befor three cycles (six months Expected compliance with and procedure is 100%. Responsible person: Direct Nursing Completion Data 02/05/2010.	rence and eport, cian and review orted to strator, monthly s). policy or of	2/5/201	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			445071	B. WIN			C 01/22/2010		
ı		PROVIDER OR SUPPLIER PRNE COUNTY NURSI	NG HOME	1	1	REET ADDRESS, CITY, STATE, ZIP CODE 850 OLD KNOXVILLE ROAD AZEWELL, TN 37879	01/2	22/2010	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOTO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE	
F 226	Continued From page 1 office, revealed the resident had a discoloration (bruise) on the forehead on November 23, 2009, of unknown etiology. Continued interview with the DON revealed the nurse on 11-7 shift gave verbal report to the 7-3 shift nurse the resident had bruise on forehead. Further interview with the DON confirmed the nurse did not document the bruise or notify the DON. The DON confirmed the staff reported the bruise on November 30, 2009 (7 days), at which time the investigation was initiated. Interview with the DON on January 21, 2010, at 10:10 a.m., in the DON's office, confirmed the facility failed to implement policy and follow procedures.			226	F 281				
		The services provided must meet profession. This REQUIREMENT by: Intakes: TN00024597. Based on medical refacility failed to follow resident (#1) of five refacility failed to follow resident (#1) and five refacility failed to follow resident (#1) of five refacility failed to follow resident (#1) and five resident (#1) and five resident #1 was adm February 9, 2000, with Dementia, Diabetes, Hypertension. Medic Minimum Data Set darevealed the resident	cord review and interview the physician's orders for one esident's reviewed.	F 2	81	Resident #1 cited in the deficiency practice was assessed by the Machine Coordinator and found on 11/2 that Resident didn't have the ordered padded side rail applied. Investigation identified that pawas removed for laundering as staff failed to reapply. Paddin side rails was reapplied. Responsible person: MDS Coordinator. Completion Da 11/30/2009 Mandatory staff education for Nursing Home housekeeping department will be conducted stressing the importance of replacing side rail padding immediately after cleaning or in padding must leave room then replace with another set of padding times in the conductor of the	MDS 30/09 ed. adding nd g for ate	11/30/0	09

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Event ID: NTEZ11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445074	B. WI				С	
NAME OF C	200//000	445071		_		01/2	22/2010	
NAME OF PROVIDER OR SUPPLIER CLAIBORNE COUNTY NURSING HOME				1	REET ADDRESS, CITY, STATE, ZIP CODE 850 OLD KNOXVILLE ROAD AZEWELL, TN 37879			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	transfers, and was rabusive behaviors a Medical record revied dated October 2009 have padded side rational linearies with the Dispanaury 21, 2010, at office, revealed the roon the forehead on lunknown etilogy. Co DON verified the resperiods of combative Further interview wit 2010, at 10:10 a.m.,	ew of the physician's orders, revealed the resident was to ails. rector of Nursing (DON) on to 10:10 a.m., in the DON's resident had a discoloration November 23, 2009, of continued interview with the sident was resist to care and to behaviors. the DON on January 21, confirmed at the time of the resident's forehead, the	F2	281	Responsible person: Houseke Supervisor. Completion Date 02/11/2010 The MDS Coordinator will re 100% of Resident charts to enthat the C.N.A. worksheets an plans are current and complete 100% of Resident rooms have audited by Ward Clerks to ensthat all patient care/safety item in appropriate use as listed on worksheets and care plans. Responsible person: Director Nursing. Completion Date 02/05/2010 Weekly monitoring will be performed by Ward Clerks Fe – April 2010 to ensure that 10 Residents have 100% of patie safety/care items in use as list worksheets and care plans. A will be completed after each a by the assigned Ward Clerk. I will be aggregated and reporte the Director of Nursing weekl the Nursing Home Administra Medical Director, and Quality Management Committee mon three times. Responsible person: Director Nursing. Completion Date 2/5	view sure d care e. been sure ins are the of bruary 0% of int ed on log audit Results ed to y and intor, thly	2/05/10	

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